

➔ 'Safety Counts' at Hallmark

William Doherty MD,
EVP and CMO
Joanne Marqusee,
EVP and COO
Co-Chairs,
Culture of Safety
Leadership
Committee

"Safety Counts" is the name we've given to a system-wide effort kicked off earlier in the year to support and communicate our ongoing commitment to quality and safety.

This commitment to patient, visitor, and staff safety is not new. We have solid safety and quality programs and a strong record of results. In fact, we often rank higher in measures of quality and safety than some of the most prestigious health care organizations in the U.S. Just two examples: we achieved an "A" grade in patient safety from the Leapfrog Group, a national organization committed to encouraging safer, higher quality health care; and by demonstrating compliance with national standards for health care quality and safety, we earned The Joint Commission's Gold Seal of Approval.

But even the best can improve. Even the best make mistakes. Perhaps you read a recent front-page article in the *Boston Globe* about Brigham and Women's Hospital documenting their mistakes publicly so their physicians and staff can learn from them. We recognize that to become even better, we must discuss and learn

from our mistakes, too.

One of our touchstones for this work is what we learned from the Culture of Safety survey conducted last year, in which more than 700 employees and staff participated. Three immediate "lessons learned" emerged from the survey.

- We need, like Brigham and Women's (and other leading health care systems such as Cleveland Clinic and Johns Hopkins), to share stories with all of you about what *hasn't* gone so well – to learn from "near misses" and errors so that we can make care safer and better.

- We need to work toward an environment in which every staff member feels comfortable speaking up about possible safety and quality issues.

- And we need to increase visibility and communications throughout the system about safety issues.

We've taken these lessons and other data from the survey to help develop a plan. Our primary areas of focus for 2013 are management involvement in patient

We need...to learn from
"near misses" and errors so
that we can make care safer
and better.

safety, communication and feedback about patient safety, and communication openness.

In fact, patient safety is a major initiative for Hallmark Health System for this year and

beyond, and it's a program that's supported right from the top – including our Board of Trustees and CEO Mike Sack. We've formed a multidisciplinary committee of members across our system of care to guide us and we are working to coordinate the many efforts to improve patient safety and promote and embrace a "culture of safety" to improve care.

We hope you will join us in supporting the "Safety Counts" campaign. There are a number of ways to do this. You can participate in our trainings and read our safety materials (such as this newsletter and the current safety-related Cornerstone Boards). You can be on the lookout for colleagues who you'd like to nominate as "Safety Stars." And, most of all, you can speak up when you see an opportunity to improve patient care and safety.

➔ CASE STUDY

Door Sensor Offers a Simple Fix to a Potential Safety Issue

Sometimes, it's just a matter of noticing a potential safety problem right at your own door.

There's a windowless door that separates the outpatient waiting room from the urgent care area at Lawrence Memorial Hospital. It takes a badge to open the door and when it does, it opens quickly, with no warning to anyone on the other side.

"The restrooms are in the urgent care area, so the door gets used a lot by people in the waiting room," said Evelyn Franzese, PBT, ASCP, phlebotomy supervisor in the nearby lab. "One day, I saw the door starting to open as an elderly woman using a walker was slowly approaching it. So I reached out and stopped it before it hit her. She wouldn't have been able to get out of the way in time."

That prompted her to file an RM Pro report about the almost-incident. And that prompted the installation of a sensor on one side of the door. Now, if someone badges the door to open it and there's someone on the other side, the door won't open until the other side is clear.

"It was a problem waiting to happen," said Franzese. "The man who came to install the sensor got hit while he was installing it! I'm just glad I was there to help the woman and then report it. One less thing to worry about."



Evelyn Franzese checks out the sensor installed on the Urgent Care Center door.

Do you have a safety story to share?
The Safety Counts team wants to hear from you.
Email us at safetycounts@hallmarkhealth.org.

➔ About Safety Counts

“Safety Counts” on two levels.

First, it’s the theme of our overall campaign to coordinate the many efforts underway at Hallmark Health System to improve patient safety and promote and embrace a “culture of safety” throughout our organization. The campaign includes working with physicians and staff to help them communicate more effectively and work together to address safety concerns.

Second, it’s the name of our new newsletter. The newsletter is aimed at:

- helping staff and physicians understand our commitment to safety
- highlighting what works – and what doesn’t – to help us become a safer organization for patients, visitors, and staff

- recognizing safety champions and our safety successes
- sharing “real life” Hallmark Health case studies for learning and improvement.

CEO Michael Sack says that “providing a high-quality, safe environment for patients and staff is of the utmost importance at Hallmark Health. And there are many examples of people around the organization who are already doing this on a daily basis. But we can always *do* better and *be* better. We are trying to create and grow an organizational culture where everyone is engaged in thinking and talking about ways to improve that will have a significant impact on the quality of care and improved patient safety.”

➔ What is a Culture of Safety?

Google “defining a culture of safety in health care” and there are 92 million results. That shows that there are many takes on what a “culture of safety” means. For example, the CDC defines it as “the shared commitment of management and employees to ensure the safety of the work environment,” in which the safety of patients and employees is paramount.

Even without a common definition, however, there are some common themes that describe a culture of safety. These include:



Teamwork and mutual respect: Employees, staff, physicians, and patients work collaboratively to achieve common safety goals.

Communication: The ability to speak up comfortably and without worry in reporting errors or “near misses” and addressing other safety and quality issues. This includes stepping in immediately when witnessing an unfolding moment of harm.

Data and information: A system that collects, analyzes, and disseminates information from incidents and near misses.

Leadership: An organizational commitment to achieving safety, from executives and managers to front-line providers and employees, and the allocation of resources to do so.

Flexibility, transparency, and openness to change: The commitment to identify process and system errors and direct resources to rectify them.

 **Hallmark Health System**

Get on Board!

Join the Safety Counts campaign and speak up when you see an opportunity to improve the safety of patients, visitors, and staff.



Safety Counts is published by the HHS Culture of Safety Leadership Committee: Thomas Byrne, MD, William Doherty, MD (co-chair), Diane Farragher Smith, Nancy Gaden, RN, Diane Hanley, RN, Martha Krache, RN, MPH, Tessa Lucey, Alan MacDonald, Joanne Marqusee (co-chair), Maureen Pierog, RN, Diana Richardson, Steven Sbardella, MD, Johna Wasdyke. Copy is reviewed and approved by committee members.